



**Guardianship New Client Assessment
Submission:**

Date of

THINGS TO KNOW BEFORE FILLING OUT THIS FORM:

The referral form must be filled out to completion, including any family and income sources.

The client must be on Medicaid AND receiving Social Security benefits to qualify. Any documentation of the assessments used to establish incapacity should be included with the referral application.

The Physician's Orders (PO) statement form provided on MHANI website MUST be signed by a physician.

If someone other than the doctor is filling out the form, the person filling out the form must sign the last section on the last page. The reason for incapacity must be specific to the person and the domains in life affected due to the incapacity. Statements like: IDD or dementia are too vague and will not be acceptable to the court.

Has the residential provider established themselves as Rep Payee?

The Residential Provider must have already have established themselves as Financial Representative Payee with Social Security (or be in process of doing so.)

Once we get all the information needed and verified, we will begin the process.

It can take anywhere from 6-8 weeks (about 2 months) to gain a Guardianship date on the court docket.

Guardianship is NOT the same as a Power of Attorney.

Guardianship takes away a person's civil rights. There are less restrictive alternatives to Guardianships that do not take a court appointment process, such as Power of Attorney (POA)/Healthcare Representative/Supported Decision Making/ Financial Representative Payee). These alternatives are only valid if signed, dated, and witnessed by a Notary BEFORE the person lost capacity and able to make an informed decision to choose the individual(s) to act on their behalf. MHANI's Guardianship Services program does not serve in this capacity.

MHANI files as the "Guardian of the person only" as the least restrictive form of guardianship. The petition can also list certain areas that guardianship is needed and serve as a "limited guardianship" based on areas needed the most in the various domains of a person's life.

Guardianship is established in the same county as the person lives.

MHANI currently has programs in Adams, Allen, Huntington, Kosciusko, LaGrange, Noble, Steuben, Wabash, Wells, and Whitley counties.

MHANI adopts the Standards & Ethics of the National Guardianship Association.

MHANI Guardianship Program renders guardianship in a person centered, healthcare team approach as much as possible when in the client's best interests. *The Standards & Ethics of the National Guardianship Association are applied in the context of the Indiana State Law for guardianship.*

GUARDIANSHIP FEES:

There is a **monthly \$35 guardianship fee** charged as allowed by the Indiana State Code on guardianship and will be billed for the month that guardianship is established by the court and on-going for every month going forward.

Note: Please fill in all the information requested. Areas marked with an asterisk (*) are especially important and are required. **Failure to fill in required blanks will delay the referral process.**

*Full legal name of person being referred:	*DOB:	*Age:
*Social Security Number:	*Gender:	*Race:
*(Required – narrative response) Please describe the specific reasons guardianship is being requested at this time. Describe recent changes, incidents, or declines that have led to this referral. Feel free to include relevant details such as safety concerns, decision-making challenges, or inability to meet basic needs. This is necessary for us to present to the court.		

***(Required – checklist + narrative explanation)**

Guardianship is considered a last resort. Please indicate which less restrictive alternatives have been explored and the outcome of each. For each option selected, describe the outcome and why it was insufficient or not feasible.

- ☐ Supported Decision-Making. Outcome:
- ☐ Case management / community-based services. Outcome:
- ☐ Family or social supports. Outcome:
- ☐ Other: _____

If no alternatives were attempted, please explain why:

*Where does the individual above currently live? (To meet MHANI criteria, the residential placement must have 24/7 staffing).

☐ Nursing home ☐ Waiver home ☐ Group home ☐ Other – Please specify:

*Name of Current Residential Provider		*Address		*Phone:	
*Client Admission Date to the current Residential Provider:		*Address and phone number of referred person (<u>IF different from residential provider</u>):			
Prior Provider:		Address:		Phone:	
<u>Identification Information:</u>					
Height:		Weight:		Hair color:	
				Eye color:	
Primary Language:		Form of communication:			
Vision: Glasses:		Hearing:			
Mobility/Ambulation:		Comatose:			
Diet:					
Catheter:					
Dentures:					

*Significant Medical History:

*Preferred Hospital:

*Hospitalizations in the last 90 days (about 3 months) Name of hospital/reason:

Healthcare/Medical Providers:

Specialty:	Physician Name:	Phone:

***Care Team of Current Residential Provider/Nursing Facility or hospital care team:**

Name	Title	Location	Office phone	Cell phone

***INSURANCE INFORMATION** - Due to MHANI's use of pro-bono attorneys, this information is needed to establish program criteria. Referral must be connected to a payor source:

*Medicare #:	*Medicaid #:
Other insurance:	Social Security Amount (per month):

***INCOME and/or Assets** - Due to MHANI's use of pro-bono attorneys, this information is needed to establish program criteria. MHANI does not have the manpower or resources to liquidate assets.

Do not leave Blank.

Source	Amount (per month)
1.	\$
2.	\$
3.	\$

Does the individual have any assets?

☐ Yes (provide details below) ☐ No (skip directly to Advance Directive)

Assets	Location	Value
Real estate		
Vehicle		
Stocks		
Bonds		
Annuity		
Trust Fund		
Checking Accounts		
Savings Accounts		
Life insurance		
Last will		
Funeral trust		
Burial plot		

	Name of person:	Phone/Address:
*Currently under Guardianship:		
*Financial Representative Payee:		

*Power of Attorney:		
*Health Care Representative:		
Does the individual have a living will? ☐ Yes ☐ No		
Does the individual have an advance directive? ☐ Yes ☐ No		
Is current residential provider applying to be the Representative Payee? ☐ Yes ☐ No		
Does the individual have end of life wishes? ☐ Yes ☐ No		

What does a meaningful day look like for the individual?

Workshop:
Day Program:
Competitive Employment/Other:
Client interests:
Current Medicaid Waiver Person-Centered Individual Support Plan (PCISP) including Date : Current Nursing Facility Plan of Care:

***FAMILY:** To show the court that due diligence was done & immediate family was notified, it is important to have any family member or community contact listed for the person being referred.

	<u>Name</u>	<u>Address</u>	<u>Contact #</u>
MOTHER			
FATHER			
SIBLING			
SIBLING			

SPOUSE			
CHILD			
CHILD			
CHILD			
CHILD			
CHILD			
OTHER			
OTHER			

Please include any known Social History:

***INDIVIDUAL CAPACITY:** Completing this information provides a baseline of functionality to allow MHANI to confirm at the face-to-face interview and be sensitive of the time to the individual and care team staff.

Y/N	Is the person able to:
	<u>Communication</u>
	Communicate verbally (Expressive)
	Communicate with gestures
	Understand what is spoken (Receptive)
	State name
	Respond to name when spoken
	State location
	State date/season
	Follow 1-step directions
	Follow 2-step directions
	Follow complex directions
	Speak 1-word statements
	Speak 2-word statements

	Use complex sentences to express self
	Able to stay with a conversation without getting off track
	Understood only by those who know them well
	Understood by all they interact with
	Write name
	Read name
	Write simple words
	Read frequently used words
	Read complex sentences
	State names of family members
	State names of people common to them on care team
	Recognize familiar people
	Live in the present
	Respond /react to their surroundings
	Identify pain or other health issues
	Track daily routine
	<u>Physical/Medical</u>
	Understand the importance of taking medications
	See with or without glasses
	Transfer from sitting to lying down without assistance
	Does person have need of mechanical lift for transfers
	Understand the importance of good hygiene
	Continent of bowel and bladder
	Toilet self and manage all toileting tasks
	<u>Safety/Welfare</u>
	Understand personal safety
	Understand consequences of unsafe situations
	Use the telephone to call 911
	Identify when they are hungry
	Understand importance of good nutrition
	Know the difference between food and non-food items
	Know the need for clothes appropriate for the season/weather
	Identify and adjust temperatures for hot and cold

	<u>Adult Daily Living Skills</u>		
	Basic home management: dusting, sweeping, mopping etc.		
	Appropriately operate appliances to wash, dry, fold, and put away laundry		
	<u>Personal Finances</u>		
	Count bills and coins		
	Make purchases at the store without assistance		
	Knows the amount and source of personal income		
	Ability to defer spending or save for a specific purchase		
	<u>Legal</u>		
	Understand the need for a guardian		
	Ability to contact an attorney and request legal advice		
	Sign and understand documents if presented to them to give informed consent		
What is the individual's level of mobility? ☐ Walks independently ☐ Walks with a cane ☐ Walks with a walker ☐ Requires a wheelchair			
Please indicate the appropriate level of the individual's personal care: Can the individual: ☐ Pick out own clothes from the closet: ☐ Independent ☐ With Cues ☐ Full Staff Care ☐ Choose clothes from choice of two outfits: ☐ Independent ☐ With Cues ☐ Full Staff Care ☐ Staff Chooses Clothes			
Complete Wash - Upper Body	☐ Independent	☐ With cues	☐ Full staff care
Complete Wash - Lower Body	☐ Independent	☐ With cues	☐ Full staff care
Complete-Wash Hair	☐ Independent	☐ With cues	☐ Full staff care
Complete-Brush Teeth	☐ Independent	☐ With cues	☐ Full staff care
Complete-Dress Upper Body	☐ Independent	☐ With cues	☐ Full staff care
Complete-Dress Lower Body	☐ Independent	☐ With cues	☐ Full staff care
Complete-Comb Hair	☐ Independent	☐ With cues	☐ Full staff care
Notes: Please include any additional information not asked for on this form that would assist in MHANI's processing.			

I certify that the information provided is accurate and that reasonable efforts have been made to explore less restrictive alternatives to guardianship prior to this referral.

*Assessor signature: _____ *Date:

*Contact Information:

****I have read and acknowledge there is a \$35 monthly Guardianship Fee associated with MHANI'S Guardianship Services.****

*Signature: _____ *Date:
